Shannon Schuster
Director, Regulatory Affairs
Government Programs
UnitedHealthcare
3100 AMS Blvd
Green Bay, WI 54313
920-661-6217

To: Centers for Medicare and Medicaid Services
Submitted electronically via: www.regulations.gov

From: Shannon Schuster
UnitedHealthcare
UnitedHealth Group

Date: December 23, 2016

Re: *Three-Year Network Adequacy Review for Medicare Advantage Organizations*

Attached are comments regarding the Three-Year Network Adequacy Review for Medicare Advantage Organizations.

Three-Year Network Adequacy Review for Medicare Advantage Organizations

Comments Submitted by
UnitedHealthcare
12/23/17

UnitedHealthcare is pleased to provide the Centers for Medicare & Medicaid Services (CMS) comments regarding the Three-Year Network Adequacy Review for Medicare Advantage Organizations (MAOs). We support the proposal to conduct three-year network adequacy reviews. We understand the need for CMS to conduct appropriate and timely compliance monitoring to ensure that all active MAO contracts offering network-based plans maintain an adequate network. Our comments are focused on the importance of ensuring that the review process instructions and expectations are clear and consistent with the regulatory standards for network adequacy. We also offer some comments focused on ensuring the burden estimates are accurate so CMS and MAOs can plan properly and prevent any unintentional process delays or quality issues due to unanticipated workload burdens. In addition, we recommend that CMS eliminate the full contract-level review from the Service Area Expansion (SAE) application process. We believe it is more appropriate, effective, and efficient for CMS to monitor MAO network adequacy in active counties through this new three-year network adequacy review process rather than through the SAE application process.

Network Adequacy Review Process – Consistency with Regulations/Clarity of Instructions
Exception Request Approval Criteria and Process Instructions

UnitedHealthcare believes that the criteria for approving or denying exceptions should be consistent with the regulations at 42 CFR §422.112(a)(10), which state that when CMS is evaluating MA networks, CMS must consider prevailing patterns of community health care delivery including the "number and geographical distribution of eligible health care providers available to potentially contract with an MAO…." and the "prevailing market conditions in the service area of the MA plan" such as "the number and distribution of health care providers contracting with other health care plans (both commercial and Medicare) operating in the service area of the plan." In the 2017 application process, however, CMS applied a standard in the exception request review process that was inconsistent with these regulations.

We appreciate CMS' more recent consideration and efforts to ensure the standard applied in the exception request review process is consistent with these regulations going forward. Specifically, we support the CMS changes to the exception request template to add additional "Reason for Not Contracting" drop down menu options, including providers/facilities that do not contract with any MAOs and providers/facilities that are at full capacity and, therefore, not able to contract with any additional MAOs.

We respectfully request that CMS also consider approving exceptions for providers/facilities that are employed or owned by an MAO, such as a staff-model HMO, that does not contract with other MAOs (e.g., physicians employed by Kaiser Permanente), and for providers/facilities that enter into exclusive agreements with one MAO and are prohibited under contract from entering into agreements with other MAOs. These are providers/facilities that do not, under any circumstances, contract with other MA organizations. These providers therefore are not actually "available to potentially contract with an MAO" under 42 CFR §422.112(a)(10)(i), and CMS

should consider this factor and the prevailing market conditions in reviewing these exceptions requests. If CMS fails to consider these factors, the unintended consequence will be a reduction in beneficiary choice of Medicare Advantage plans because the only MAO that can meet the Health Service Delivery (HSD) criteria will be the MAO that employs or owns or enters into an exclusive agreement with these providers.

We also raise concerns with language included in the PRA Supporting Statement, Use Of Information Technology section, which states:

> Current CMS policy states that an MAO that does not pass the network adequacy criteria for a particular provider or facility type in a given service area may request an exception. If the contracted provider network is consistent with the current pattern of care and *provides enrollee access to covered services that is equal to or better than the prevailing original Medicare pattern of care*, then an exception may be granted." (Emphasis added.)

We are very concerned that this statement is likewise inconsistent with the regulations at 42 CFR §422.112(a)(10) as the regulation does not require an MAO to provide access that is "equal to or better than the prevailing original Medicare pattern of care." In fact, the nature of network-based Medicare Advantage plans is for the MAO to contract with a *smaller* subset of Medicare providers who work to coordinate care for the MA plan members. Therefore, UnitedHealthcare recommends that CMS remove this language and instead use the language from §422.112(a)(10), which states that when CMS is evaluating MA networks, CMS must consider prevailing patterns of community health care delivery. This includes the "number and geographical distribution of eligible health care providers available to potentially contract with an MAO…." and the "prevailing market conditions in the service area of the MA plan" such as "the number and distribution of health care providers contracting with other health care plans (both commercial and Medicare) operating in the service area of the plan."

Health Service Delivery Upload Request Letter Timing

This collection of information requires the uploading of HSD tables to the Network Management Module (NMM) in the Health Plan Management System (HPMS) for any contract that has not had an entire network review performed by CMS in the previous three years of contract operation. Every MAO that holds a contract that is due for its three-year entire network review will receive a letter specifying which contracts are due for review, the reason for the request, a description of CMS's network adequacy requirements, instructions on how to upload current HSD tables for the specified contract, a notation that CMS may take compliance actions if network deficiencies are found, and pertinent contact information for the MAO's reference. CMS has proposed for these request letters to be sent out at the same time each year, preferably in September. However, MAOs will already be preparing for the next year's expansion filing in September. For that reason, we ask that these request letters be sent out in August, rather than September.

HPMS Contract Anniversary Date

MAOs receiving HSD upload request letters will have recently passed the "anniversary" of their contracts' three-year entire network review and CMS will continuously track these contract anniversary dates. We request that CMS make the "Contract Anniversary Date" reports

downloadable from HPMS, which would ensure that MAOs are prepared for network HSD tables and exception requests.

Administrative Burden Estimates
Hour Per Response and Annual Hour Burden

CMS may have significantly underestimated the hour burden due to the way CMS posed the questions and aggregated the results of the responses received. Specifically related to the development of HSD tables, CMS is estimating 15 hours for the development of an HSD table for a single *contract*. We do not believe this is accurate or appropriate. Rather, it would be more appropriate for CMS to request responses and estimate the number of hours it takes to develop an HSD table based on a single *county*. The size of a CMS contract can vary significantly from one county to hundreds of counties. A contract with hundreds of counties will take significantly longer than 15 hours for the development (including quality review) of an HSD table. For this reason, we are concerned that the hour burden is significantly underestimated for HSD table development. We propose that approximately 15 hours for the development (including quality review for accuracy) of an HSD table for a single county is a reasonable estimate. Additionally, we are concerned about the capability of the HPMS NMM to handle large HSD submissions. We had recent experience with large contracts (with hundreds of counties) taking 3 or more days to complete the automated criteria check (ACC) process in the HPMS NMM, which hampered response time to CMS and increased the time spent by MAOs in checking the status of the ACC availability. Therefore, we recommend CMS confirm the HPMS NMM will have the capacity for processing ACCs for 300+ contracts in the same time period, in order to avoid these kinds of delays with ACC processing during these reviews.

We have similar concerns related to CMS underestimating the hour burden related to the development of exception requests. CMS is estimating 8 hours per exception request. We are concerned that these responses were requested from the sampled MAOs at a time when CMS was changing the exception request process, and the MAOs did not have enough experience with the new exception request process or instructions to be able to accurately estimate the hour burden. Additionally, it is not clear whether consideration has been given to the amount of time that MAOs are spending researching and responding to inaccurate provider data contained in the CMS provider data sources, which results in the need for exceptions to be requested. Additionally, it is not clear whether consideration was given to the fact that an MAO can choose to withdraw or exit a county rather than submit an exception in the SAE application process that was used to estimate these hour burdens. This may have resulted in CMS underestimating the number of exceptions that will be requested in the three-year network adequacy review process, when MAOs do not have the option to withdraw or exit a county rather than submit an exception request.

We also recommend that CMS eliminate the full contract-level review from the Service Area Expansion (SAE) application process. We believe it is more appropriate, effective, and efficient for CMS to monitor MAO network adequacy in active counties through this new three-year network adequacy review process rather than through the SAE application process. Eliminating the requirement for full contract-level review in the SAE application process will help to reduce the overall annual burden on CMS and MAOs.

Cost to Federal Government

CMS stated the business operations surrounding the network adequacy information being collected are already in place, and no new hours or support staff will be incurred with this new collection of information request. We are concerned that CMS may not be considering the impact of the additional 304 full contract-level network adequacy reviews that CMS estimates will need to be completed in Year 1. These reviews represent work that is not done today within CMS, so unless CMS staff are going to stop doing something else in order to do this work, this must represent new hours incurred by CMS staff that are not incurred today. Each contract review, depending on the number of counties in the contract, and the number of exceptions that are requested, could potentially represent a significant number of hours incurred. We are concerned that if CMS is not properly estimating the work hours and staff needed, this will potentially result in similar process delays and quality issues in the new review process as those recently experienced by CMS and MAOs in the 2017 SAE application process in early 2016.

If you have any questions on these comments, please feel free to contact me at 920-661-6217.

Respectfully,

Shannon S. Schuster

Shannon Schuster
Director, Regulatory Affairs
UnitedHealthcare